



Attention Medical Records
 5496 East Taft Road, North Syracuse, NY 13212

PERMISSION FOR VERBAL COMMUNICATION

Patient Information (Please Print)

Name: Last First Middle Date of Birth

Address: Street Address City State Zip Code

I permit New York Spine and Wellness Center, their physicians, nurses and other personnel to discuss my health information, in person or by telephone, with the following family members or friends; (List family members /friends and state the relationship to the patient).

Medical Information:

Name	Phone Number	Relationship
1.		
2.		
3.		

Behavioral Health Information:

Name	Phone Number	Relationship
1.		
2.		
3.		

Release of information under this document is limited to verbal discussions. This document does not permit release of any written health information.

This authorization is limited to the following time frame from _____ (date) to _____ (date). If no dates are indicated, this form will remain in effect for an unlimited amount of time or until it is revoked in writing.

If, at any time I do not want verbal discussions to be permitted between NYSWC and any individuals named above, I must notify NYSWC by contacting my provider.

Signature of Individual _____

Date _____

If this Authorization is to be signed by a Personal Representative of the Individual, please complete the following:

Signature of Personal Representative _____

Printed Name of Personal Representative _____ Date _____

Description of authority: _____
 (A personal representative must provide legal proof of representation, e.g., guardian, health care proxy, Power of attorney)